MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7621

CERTIFICATE OF DEATH

07570

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Woodland Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Aurndel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Woodland Beach
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle BENJAMIN Last ALBRITTON

4. DATE OF DEATH: Month July Day 18 Year 19 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 19, 1877
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired U.S.Gov.
10b. KIND OF BUSINESS OR INDUSTRY: Printer
11. BIRTHPLACE (State or foreign country): Farmington, Ky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
INFORMANT: Mina B. Albritton- wife- same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia & pyelitis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b): Carcinoma of bladder — at least 1 year

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

181.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Nov, 19 59 to July 18, 1960, that I last saw the deceased alive on July 17, 1960, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 7/19/60

PHYSICIAN'S NAME (Type): Willard F. Smith MD — Shady Side, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 20, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hopping Funeral Home Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: JUL 21 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7622

CERTIFICATE OF DEATH

07571

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 7 mo. 5 years 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1932 W. Lanvale Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Georgia — Middle: — Last: Autry

4. DATE OF DEATH: Month: 7 — Day: 29 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: February 28, 1896

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William McSwain

14. MOTHER'S MAIDEN NAME: Annie Bobbett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address: A. A. County, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Hyperthyroidism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

252.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Hour a. m. p. m. ----- Month, Day, Year 19 ------

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -----

20f. (City or town) ------ (County) (State)

21. I certify that I attended the deceased from ____, 19____, to 7/29, 1960, that I last saw the deceased alive on 7/29, 1960, and that death occurred at 7:35A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/29/60

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. 7/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August, 1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: James Morton Jr. — ADDRESS: 916 Pennsylvania Ave

24a. REC'D BY REGISTRAR DATE: AUG 2 '60

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7584

07572

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Severna Park
d. STREET ADDRESS: Rt-1, Box- 167
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harold — Middle: O'NEIL — Last: BERRYMAN

4. DATE OF DEATH: Month: July — Day: 6 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 7, 1891

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALES MANAGER CAN CO. RETIRED 8YRS

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland, Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN BERRYMAN

14. MOTHER'S MAIDEN NAME: EMMA HAGGART

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215 09 6026

17. INFORMANT: Address: MRS ROSAMOND BERRYMAN SEVERNA PARK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 5, 19 60 to July 6, 19 60, that (I) (~~was~~ last saw the deceased alive on July 6, 1960, and that death occurred at 2:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 7-6-60

22c. PHYSICIAN'S NAME (Type): Richard N. PEELER

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 7/9/60
23c. NAME OF CEMETERY OR CREMATORY: PARKWOOD CEMETERY
23d. LOCATION (City, town, or county) (State): BALTIMORE MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HENRY SANDER & SONS INC. BALTIMORE MD.

25a. REC'D BY REGISTRAR DATE: JUL 8 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7623

07573

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Pasadena
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Pasadena, Maryland
d. STREET ADDRESS: Poplar Ridge, Cedar Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roy — Middle: EUGENE — Last: BEZIAT

4. DATE OF DEATH: Month: JULY — Day: 12 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 19, 1911

9. AGE (In years last birthday): 48 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIPFITTER, U.S. COAST GUARD

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ROY ELLSWORTH BEZIAT

14. MOTHER'S MAIDEN NAME: ELSIE MOCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: U.S. Govt

17. INFORMANT: MRS. EMMA BEZIAT — Address: PASADENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 Minutes
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May 2, 1950, to July 12, 1960, that (I) (~~we~~) last saw the deceased alive on July 12, 1960, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: R. M. McLaughlin — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: July 12, 1960

22c. PHYSICIAN'S NAME (Type): R.M. McLAUGHLIN

22d. ADDRESS: 3708 Mountain Rd. Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/15/60

23c. NAME OF CEMETERY OR CREMATORY: ~~Meadowridge~~ Cohen / Hayden Cem.

23d. LOCATION (City, town, or county) (State): ~~Elkridge Cem.~~ Glen Burnie, Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully Funeral Homes 130 E. Fort Ave. # 30 2nd D

25a. REC'D BY REGISTRAR DATE: JUL 18 '60

25b. REGISTRAR'S SIGNATURE: Clinton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7585

CERTIFICATE OF DEATH

07574

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Mitchellville 16x-2
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: Oswald; Last: BOTELER

4. DATE OF DEATH: Month: July; Day: 7; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1891

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Tobacco Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Tenent

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: Charles Lyn Boteler

14. MOTHER'S MAIDEN NAME: Margaret Ann Perrie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Isabel I. Boteler-Same as Item #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 da
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: ; o. m. / p. m.: ; Month: ; Day: ; Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 30, 1960 to July 6, 1960, that (I) (~~saw~~) last saw the deceased alive on July 6, 1960, and that death occurred at 2:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard N. Peeler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 7-7-60

22c. PHYSICIAN'S NAME (Type): Richard N. Peeler

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/11/60

23c. NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery

23d. LOCATION (City, town, or county) (State): Clinton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ritchie Bros. Fun'l Home-Upper Marlboro Md.

25a. REC'D BY REGISTRAR DATE: JUL 11 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 11/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7624

CERTIFICATE OF DEATH

Reg. Dist. No. 07575

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 3 yrs. 22 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Turner's Station
d. STREET ADDRESS: 111 Avon Beach Road
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐ — Rural

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: Ruth — Last: Bumgardner

4. DATE OF DEATH: Month: 7 — Day: 6 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 25,1903

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Hurt

14. MOTHER'S MAIDEN NAME: Sue Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 214-24-6385

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
(b): Hypertensive Cardiovascular Disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4437

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ———

20c. TIME OF INJURY: Hour o. m. p. m. ——— Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. I certify that I attended the deceased from 6/14 1957 to 7/6 1960 that I last saw the deceased alive on 7/6 1960 and that death occurred at 5:45A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/6/60

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. — 7/6/60

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-10-60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

22d LOCATION (City, town, or county) (State): A. A. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles B. Lewis — ADDRESS: 1639 N. Broadway

24a. REC'D BY REGISTRAR DATE: AUG 8 '60

24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7586

07576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 13 min.
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Arnold
   d. STREET ADDRESS: Rt-2, Box-583
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henryetta — Middle: WAGNER — Last: CARPENTER

4. DATE OF DEATH: Month: July — Day: 13 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-21-1911

9. AGE (In years last birthday): 49 yrs
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER

10b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOLS

11. BIRTHPLACE (State or foreign country): Arizona

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: THOMAS WAGNER

14. MOTHER'S MAIDEN NAME: ODA JosepHine WRIGHT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
    (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: THOMAS P CARPENTER # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma (so)
DUE TO (b): Carcinoma of Breast
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 months / 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21) I certify that (I) (this hospital) attended the deceased from Feb 6, 1957 to July 13, 1960, that (I) (~~last~~) last saw the deceased alive on July 13, 1960, and that death occurred at 5:15P.M. from the causes and on the date stated above.

22a SIGNATURE: [signature] M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 7/14/60

22c PHYSICIAN'S NAME (Type): James R. Martin

22d ADDRESS: 6 Shaw St., Annapolis, Md.

23a ~~BURIAL~~ CREMATION, REMOVAL (Specify): CREMATION

23b DATE THEREOF: 7-16-1960

23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN

23d LOCATION (City, town, or county) (State): PRINCE GEORGE Co. MD

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: JOHN M. TAYLOR SON ANNAPOLIS MD

25a. REC'D BY REGISTRAR — DATE: JUL 18 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinnas

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7587 — Item 8 Filed 8-15-60 — 07577

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c LENGTH OF STAY IN 1b: 2 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: R 4 - Box 45
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elery; Middle; Last COLBERT
4. DATE OF DEATH: Month July; Day 25; Year 1960

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 27, 1903
9 AGE (In years last birthday): 56 57 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: William Colbert
14 MOTHER'S MAIDEN NAME: Mary Hunt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Gladys Colbert R 4 Box 45 Anna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Anemia
DUE TO (b): Renal Disease, malignant Hypertension
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: about 1 mos

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 23, 19 60 to July 25, 19 60, that (I) (~~last~~) saw the deceased alive on July 25, 1960, and that death occurred at 7:20 P.M. from the causes and on the date stated above

22a SIGNATURE: A. T. Allen M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/26/60
22c PHYSICIAN'S NAME (Type): A. T. Allen
22d. ADDRESS: 62 Cathedral St., Annapolis, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 7-29-1960
23c NAME OF CEMETERY OR CREMATORY: Broadneck
23d LOCATION (City, town, or county) (State): St Margaret Md.

24 FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Anna Md.
25a REC'D BY REGISTRAR DATE JUL 28 '60
25b REGISTRAR'S SIGNATURE: Osburn S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7625

CERTIFICATE OF DEATH

07578
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Dorchester ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN 1b: 2 years 5 mo. 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital	d. STREET ADDRESS: Unknown — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Rose	Lee	Collins	7	6	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Female	Negro		1884	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	--------	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Tissa ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unknown	Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Decubital Ulcers

DUE TO

(c) Central Nervous System Syphilis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---- 19		------	------

21. I certify that I attended the deceased from 1/23, 1958, to 7/6, 1960, that I last saw the deceased alive on 7/6, 1960, and that death occurred at 3:30P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Maryland — DATE SIGNED: 7/7/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M.D. — Crownsville State Hospital, Maryland — 7/7/60

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	7/15/60	Univ. of Maryland	Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm Reese II	108 W. Washington St. Easton	JUL 19 '60	Clifton T. Perkins

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07579

7626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2. USUAL RESIDENCE (Where deceased lived — If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Box 201, Route 5

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Box 201, Route 5, Magothy Beach

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Magothy Beach, Pasadena

2d. STREET ADDRESS: Pasadena

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Johanna — Middle: Paul — Last: Colyer

4. DATE OF DEATH: Month: July — Day: 30, — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1867

9. AGE (In years last birthday): 93 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs. Howard Tydings, Same as

MEDICAL CERTIFICATION

1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): acute cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hours

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular disease — 2 years

DUE TO (c): Cardiac decompensation — 5 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1959, to July 30, 1960, that I last saw the deceased alive on July 29, 1960, and that death occurred at 1 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D: C. P. McLaughlin — ADDRESS (Street, city or town, state): 3705 Mountain Rd. Pasadena, Md. — DATE SIGNED: 7/30/60

PHYSICIAN'S NAME (Type): C. P. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/2/60

22c. NAME OF CEMETERY OR CREMATORY: Glen Havem Memorial

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Kirkley — ADDRESS: Hopping & Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 2 '60

24b. REGISTRAR'S SIGNATURE: Catherine E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7627

CERTIFICATE OF DEATH

Reg. Dist. No. 07580

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUT ON: 404 Forest View Road

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
d. STREET ADDRESS: 404 Forest View Road
e. IS RES DENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ROSINA Middle B. Last CONAWAY

4. DATE OF DEATH: Month July Day 14, Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 29, 1873
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry William Herman
14. MOTHER'S MAIDEN NAME: Rosa Dora Oehrl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Florence Hennessy-404 Forest View Rd. Address: Linth. Hgts.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertension — 10-15 yrs
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1954, to 7/14/60, 19____, that I last saw the deceased alive on 7/14/60, 19____, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE: Chas L. Ball Jr. M.D. ADDRESS (Street, city or town, state): Linthicum Md. DATE SIGNED: 7/14/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/16/60
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
22d. LOCATION (City, town, or county) (State): Pikesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Pickner & Sons ADDRESS: Baltimore 17, Md.

24a. REC'D BY REGISTRAR DATE JUL 14 '60
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1 2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07581

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 146 Defense Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle W. Last COOLEY
4. DATE OF DEATH: Month July Day 18 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH (Month, Day, Year): July 18th 1940
9. AGE (In years last birthday): 20 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lifeguard
10b. KIND OF BUSINESS OR INDUSTRY: Public Beach
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: George W. Cooley Sr.
14. MOTHER'S MAIDEN NAME: Elsie Sondergaard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes. 1958-1960
16. SOCIAL SECURITY NO.:
17. INFORMANT: George W. Cooley — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Stab Wound of Chest.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Stabbed in chest.

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
9:00 p.m.	7/18 1960		House	Annapolis	Anne Arundel	Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 7/19/60

EXAMINER'S NAME (Type): Charles S. Petty, M.D.
Address (Street, city, town or county):

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
Burial	7-22-1960	Hillcrest Memorial	Annapolis	Md

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
John M. Sayler Sons	Annapolis Md	JUL 21 '60	Arthur S. Kraus

DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

M

I

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7628 **CERTIFICATE OF DEATH** Reg. Dist. No. 07582

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Heights
c. LENGTH OF STAY IN 1b: Over 6 years

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 901 Victory Avenue

3. NAME OF DECEASED (Type or print): [redacted] T. Rose Cover (First Middle Last)

4. DATE OF DEATH: Month July Day 20th Year 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/8/98
9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Kress
14. MOTHER'S MAIDEN NAME: ? Wiegand

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 219-10-4576
17. INFORMANT: Miss Jean Cover (daughter) Address: 901 Victory Avenue #25

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2hrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardio-vascular diseases — 3 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1956, to July 20th., 1960, that I last saw the deceased alive on July 1 th., 1960, and that death occurred at 10.15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. ADDRESS (Street, city or town, state): Glen Burnie, Md. DATE SIGNED: 7/21/60

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/23/60
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tschan Sons ADDRESS: Balto - D. Md.
24a. REC'D BY REGISTRAR DATE: JUL 26 '60
24b. REGISTRAR'S SIGNATURE: William S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7589

CERTIFICATE OF DEATH

Reg. Dist. No. 07583

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN Tb:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. GENERAL Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MAYO
d STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE — Middle MYRTLE — Last COX

4. DATE OF DEATH: Month 7 — Day 8 — Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-20-1914

9. AGE (In years last birthday): 45 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEC'T.

10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.E.E.S

11. BIRTHPLACE (State or foreign country): MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: "UNK"

14. MOTHER'S MAIDEN NAME: "UNK"

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: WILLIAM E. COX SR. — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Uremia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Polycystic renal Disease
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/4, 1960, to 7/8, 1960, that I last saw the deceased alive on 7/8, 1960, and that death occurred at 6:45 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: Richard N Peeler M.D. — ADDRESS (Street, city or town, state): 121 CATHEDRAL ST — DATE SIGNED

PHYSICIAN'S NAME (Type): RICHARD N. PEELER — ANNAPOLIS, MD.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 7-11-60

22c NAME OF CEMETERY OR CREMATORY: HILLCREST

22d LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 7, 8, 9 Firm Co. Bailey-Burnett

07584

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shades River
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pier of Shades River

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Landover
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle H. — Last CRAWFORD

4. DATE OF DEATH: Month July — Day 9, — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1904

9. AGE (In years last birthday): 55 55. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer

10b. KIND OF BUSINESS OR INDUSTRY: A Eberly and sons

11. BIRTHPLACE (State or foreign country): Washington D C.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Harrison

14. MOTHER'S MAIDEN NAME: Elizabeth Ann Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Raymond L Crawford Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c)

8507

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Thrown overboard when his boat tipped over

20c. TIME OF INJURY Hour ~~XXX~~ p.m. — Month, Day, Year: 7/9/1960

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): Shades River

20f. (City or town) (County) (State): Anne Arundel, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, city, town, or county)

DATE SIGNED: 7/11/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 13, 1960

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or country) (State): Washington D C

23. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: JUL 15 '60

24b. REGISTRAR'S SIGNATURE: Arthur J Krauss

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

·7590 — 07585

1

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL 9 Severn
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Asa — Middle: Biggs — Last: DAVIS

4. DATE OF DEATH: Month: July — Day: 23 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 18, 1906

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Painter

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): North Carolina

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George ?B. Davis

14. MOTHER'S MAIDEN NAME: Sally F. Haraing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 213 18 6980

17. INFORMANT — Address: Mrs Jack Erbe- Daughter- same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA OF LUNG — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

162 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1955, to July 23, 1960, that (I) last saw the deceased alive on July 23, 1960, and that death occurred at 12:45P. M, from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 7/25/60

22c PHYSICIAN'S NAME (Type): Edward S. Beck

22d ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 26,60

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d LOCATION (City, town, or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Hopping and Kirkley Funeral Home, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUL 27 '60

25b. REGISTRAR'S SIGNATURE: Christian S. Haase

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7630

CERTIFICATE OF DEATH

Reg. Dist. No. 07586

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
d. STREET ADDRESS: 5th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle PERRY — Last DAWSON

4. DATE OF DEATH: Month JULY — Day 5 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 23, 1891

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: Carpenter

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ~~Unknown~~ James M Dawson

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Amanda Hurst

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 579 05 9234

INFORMANT: Mrs. Myrtle P. Dawson (Wife)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(b): Arteriosclerotic heart disease — Approx 5 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 29 June, 1960, to 5 July, 1960, that I last saw the deceased alive on 5 July, 1960, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry N Claman M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 5 July 1960

PHYSICIAN'S NAME (Type): HENRY N. CLAMAN, Capt MC, U.S.Army Hospital, Ft Geo G. Meade, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/9/60
22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Colgate, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ullrich Funeral Home 4210 Belair Road.

24a. REC'D BY REGISTRAR DATE: Jul 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7631 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 07587

(M)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park P.O.
c. LENGTH OF STAY IN 1b: MARYLAND 15 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carrlton Manor

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sare
d. STREET ADDRESS: / Sare
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dorothy Middle L. Last Dunbar

4. DATE OF DEATH: Month July Day 29 Year 1960 19

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/5/79

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired housewife

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Chillecothe, Ohio.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Lair

14. MOTHER'S MAIDEN NAME: Lida Bickham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Philipp Franklin (son) Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): 420.1 DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Gustave H. Faubert, M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/30/60

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 3-1960

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country): Arlington (State): Va

23. FUNERAL DIRECTOR: John M. Taylor Sons

ADDRESS: Annapolis Md.

24a. REC'D BY REGISTRAR DATE: AUG 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7618

CERTIFICATE OF DEATH

07589

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1104 Beach Promenade

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Orchard Beach
d. STREET ADDRESS: 1104 Beach Promenade
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maximillan — Middle: Conrad F. — Last: Pahmuller

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1902

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Manager

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Conrad Pahmuller

14. MOTHER'S MAIDEN NAME: Kunigunda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: ?

17. INFORMANT: Christine Pahmuller — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 mins.
DUE TO (b): Coronary Artery disease — 2 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 10, 1958 to July 28, 1960 that I last saw the deceased alive on Feb. 15, 1960 and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): Pasadena, Md. — DATE SIGNED: July 29, 1960

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-1-60

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Anne Arundel City, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Geo. L. Schwartz Funeral Home, Francis X. Miller — ADDRESS: 310 Frederick Ave

24a. REC'D BY REGISTRAR DATE: AUG 1 '60

24b. REGISTRAR'S SIGNATURE: Clarkson S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death: Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7632

CERTIFICATE OF DEATH

07588

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long Point Pasadena Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 427 E. Lorraine Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Thomas Middle Nathaniel Last Fercot
4. DATE OF DEATH: Month 7/ Day 21/ Year 60
5. SEX: M
6. COLOR OR RACE: W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegraph Oper.
10b. KIND OF BUSINESS OR INDUSTRY: M. Cubbin Feed
11. BIRTHPLACE (State or foreign country): Westernport Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chas N. Fercot
14. MOTHER'S MAIDEN NAME: Mary A McGuire

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Mr. Thos. Fercot, Jr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic Coronary Disease, Angina — 2 years
DUE TO (c): Coronary with Ang. Pectoris — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour / a. m. / p. m. / Month / Day / Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1960 to July 21, 1960 that I last saw the deceased alive on July 20, 1960, and that death occurred at 9:15 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 701 Winchester Road, Baltimore, Md. DATE SIGNED: 7/21/60

PHYSICIAN'S NAME (Type): R. M. Pickerington

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/25/60
22c. NAME OF CEMETERY OR CREMATORY: Gardens of Faith Cem.
22d. LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: WIED-FELD & SON-Greenmount Ave & 22nd
24a. REC'D BY REGISTRAR DATE: JUL 26 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7633

07590

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundle — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Patapsco Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 227 Bishop Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Baltimore - Rural
d. STREET ADDRESS: 1227 Bishop Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Walter — Last: Gibson

4. DATE OF DEATH: Month: 7 — Day: 24 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 16-1906

9. AGE (In years last birthday): 53 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Spotter

10b. KIND OF BUSINESS OR INDUSTRY: Cleaners

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Gibson

14. MOTHER'S MAIDEN NAME: Rosa Grosby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wife — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension & Arterio Sclerosis — 2-3 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m / p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 18, 1960, to July 24, 1960, that I last saw the deceased alive on July 24, 1960, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Ball Jr. MD — ADDRESS (Street, city or town, state): Linthicum, Md. — DATE SIGNED: 7/24/60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7-27-60 — 22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem — 22d. LOCATION (City, town, or county) (State): Anne Arundle Co

23. FUNERAL DIRECTOR'S SIGNATURE: Elroy O. Wilson — ADDRESS: 1000 Bonitta ave

24a. REC'D BY REGISTRAR — DATE:

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

7591 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 07591

CERTIFICATE OF DEATH

TO HOLDER OF BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 183 Janice Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gerard — Middle: - - - — Last: GORMLEY

4. DATE OF DEATH: Month: July — Day: 28 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1960

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS: Hours: 7 — Min: 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Donald Richard Gormley

14. MOTHER'S MAIDEN NAME: Betty Jo Schwieterman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

7766

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 27, 1960, to July 28, 1960, that (I) (We) last saw the deceased alive on July 28, 1960, and that death occurred at 1:45 P.M., from the causes and on the date stated above

22a SIGNATURE: Niel H. Sims M D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 7/29/60

22c PHYSICIAN'S NAME (Type): Niel H. Sims

22d. ADDRESS: 95 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 8-2-1960 — 23c NAME OF CEMETERY OR CREMATORY: Arlington National — 23d LOCATION (City, town or county): Arlington (State): Va

24. FUNERAL DIRECTOR'S SIGNATURE: Jean M. Taylor Sims — ADDRESS: Annapolis Md

25a REC'D BY REGISTRAR DATE: AUG 4 '60 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Willis

VR A1S (4) 1SM 9/59

2063263XV1

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7592

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07592

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4707 Wrenwood Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: JAMES — Middle: C. — Last: GREEN

4. DATE OF DEATH: Month: July — Day: 4 — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1929

9. AGE (In years last birthday): 30 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Social Security

11. BIRTHPLACE (State or foreign country): Balto., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua Green

14. MOTHER'S MAIDEN NAME: Mary Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes

16. SOCIAL SECURITY NO (If yes give were or dates of service): Korean

17. INFORMANT: Margaret B. Green — Address: 4707 Wrenwood ~~Street~~ Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): XXXXX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

Hypertensive and Arteriosclerotic Heart Disease with Total Occlusion of Right Coronary Artery and One Branch of Left Coronary Artery, and Old Myocardial Infarction.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. S. Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 7/5/60

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	7/8/60	Balto National Cemetery	Balto., Md.

23. FUNERAL DIRECTOR — ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Halstead & March 928 E. North Ave.	D[illegible] 6 '60	Arthur L. Krause

TO LOCAL HEALTH OFFICER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7634 **CERTIFICATE OF DEATH** Reg. Dist. No. 07593

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 25
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 147 - W. 11th Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Louis Middle Howard Last Hammond

4. DATE OF DEATH: Month July Day 9 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29-1903

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Cutter

10b. KIND OF BUSINESS OR INDUSTRY: Armour

11. BIRTHPLACE (State or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rezin Hammond

14. MOTHER'S MAIDEN NAME: Margaret Grossman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-18-1311

17. INFORMANT: Madeline Hammond — Address: Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs
DUE TO (b): Cirrosis of Liver — 18 mos.
DUE TO (c): Diabetes — 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 422.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1940, to 7/9, 1960, that I last saw the deceased alive on 7/9/60, 19____, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas. L. Bale Jr. M.D. ADDRESS (Street, city or town, state): Linthicum - Md. DATE SIGNED: 7/9/60

NAME (Type) [redacted]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-13-60

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross

22d. LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 1306 Fort Ave.

24a. REC'D BY REGISTRAR DATE: JUL 11 '60

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7593

07594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis	c. LENGTH OF STAY IN 1b: 2 days
	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Galesville,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital	d. STREET ADDRESS: /
	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Arthur	Lee	HARDESTY	July	18	1960

5 SEX	6 COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White		August 9, 1917	42 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
PLANT FOREMAN	Bottled Gas	Maryland, Galesville	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS ALVIN Hardesty	Christine A. Hardesty Galesville

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT Address
Yes WWII	220-26-4950	Ruth L Hardesty Galesville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a)	Gen. carcinomatosis	
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Carcinoma of pancreas	7 mos.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
a.m. p.m. 19			

21. I certify that (1) (this hospital) attended the deceased from January 1960 to July 18, 1960, that (I) (~~last~~ saw the deceased alive on July 18, 1960, and that death occurred at 8:50PM from the causes and on the date stated above

22a. SIGNATURE	ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
T. Borssuck M.D. M.D	8:50 P.	7/19/60
22c PHYSICIAN'S NAME (Type) Samuel Borssuck	22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.	

23a BURIAL CREMATION REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town, or county) (State)
Burial	7/21/60	Woodfields	Galesville Md

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Bernard O. Hardesty Galesville Md.	JUL 26 '60	Cletus S. Kinsey

Item 20 Film 206
7-22-(ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7594

CERTIFICATE OF DEATH

Reg. Dist. No. 07595

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Convalescent Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Annapolis
d. STREET ADDRESS: 1 4 Randall Court

3. NAME OF DECEASED (Type or print): First: Mattie — Middle: V. — Last: Hardesty

4. DATE OF DEATH: Month: July — Day: 9 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 8, 1883

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm E. Hardesty

14. MOTHER'S MAIDEN NAME: Martha Chaney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Mae L. Hardesty — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular renal
DUE TO (b): fracture pubis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

9 2 7

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT FY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell off of chair at home

20c. TIME OF INJURY: Hour 11 p. m. — Month, Day, Year: 6-10 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Annapolis — (County): An — (State): Md

21. I certify that I attended the deceased from June 5, 1960 to July 9, 1960 that I last saw the deceased alive on July 8, 1960, and that death occurred at 6 00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D — ADDRESS (Street, city or town, state): Luthern, Md. — DATE SIGNED: 7-11-60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 11, 1960

22c. NAME OF CEMETERY OR CREMATORY: St. James Cemetery

22d. LOCATION (City, town, or county): Traceys — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Son — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Franz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7635 CERTIFICATE OF DEATH

Reg. Dist. No. 07596

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
d. STREET ADDRESS: 7006-C Antelak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALBERT Middle N. Last HARPER

4. DATE OF DEATH: Month July Day 13 Year 19 60

5. SEX: MALE

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 13 July 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours 3 Min 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emanuel Harper

14. MOTHER'S MAIDEN NAME: Evelyn L. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service): N/A

16. SOCIAL SECURITY NO.: N/A

INFORMANT Address: Mr. Emanuel Harper, 7006 C Antelak St, Ft Meade Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme prematurity — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 July, 1960, to 13 July, 1960, that I last saw the deceased alive on 13 July, 1960, and that death occurred at 7:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur H. Miller M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 13 July 60

PHYSICIAN'S NAME (Type): WILBUR H. MILLER, JR., CAPT, MC U. S. Army Hospital, Ft Geo G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 13 Jul 60
22c. NAME OF CEMETERY OR CREMATORY: Laboratory, U.S. Army Hospital
22d. LOCATION (City, town, or county) (State): Ft Geo G Meade, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: B.M. Ellis
ADDRESS: Capt., MSC, USAH, FGGM

24a. REC'D BY REGISTRAR DATE: JUL 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A75 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7636

CERTIFICATE OF DEATH

07598

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West River
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: — Last: Harvey

4. DATE OF DEATH: Month: 7 — Day: 8 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-31-1915

9. AGE (In years last birthday): 44 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truckdriver

10b. KIND OF BUSINESS OR INDUSTRY: Constr

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Harvey

14. MOTHER'S MAIDEN NAME: Rebecca Peters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-24-1019

17. INFORMANT: Elizabeth Harvey Address: West River Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the Right Superior

DUE TO (b): Maxillary Sinus — INTERVAL BETWEEN ONSET AND DEATH: 5 Mo

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 160.2

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 19 1959 to July 6 1960, that (I) (we) last saw the deceased alive on July 6 1960, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Richardson M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/11/60

22c. PHYSICIAN'S NAME (Type): R. L. RICHARDSON

22d. ADDRESS: 110-20 Jay St Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7-12-60

23c. NAME OF CEMETERY OR CREMATORY: House of prayer

23d. LOCATION (City, town, or county): West River Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese Jr. — ADDRESS: Anna. Md.

25a. REC'D BY (REGISTRAR) DATE: JUL 13 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Trump

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7595 07599

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 8 Kirbys Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First — Middle — Last: HENSON

4 DATE OF DEATH: Month: July — Day: 30 — Year: 19 60

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 30, 1960

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days — Hours: 2 — Min.: 50
IF UNDER 24 HRS

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Donald B. Henson

14 MOTHER'S MAIDEN NAME: Miriam Makell

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT: Donald Henson — Address: Annapolis Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Erythroblastosis Fetalis - Anemia — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 770.0
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 30, 1960, to July 30, 1960, that (I) saw last saw the deceased alive on July 30, 19 60 and that death occurred at 11:00 P.M., from the causes and on the date stated above

22a SIGNATURE: Philip Proctor M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 8/1/60

22c PHYSICIAN'S NAME (Type)

22d ADDRESS: 95 La Bedure St Annapolis Md

23a BURIAL, CREMATION, REMOVAL (Specify) — 23b DATE THEREOF: Aug 2 '60 — 23c NAME OF CEMETERY OR CREMATORY: Brownwich — 23d LOCATION (City, town, or county) (State): St Mary's Co Md

24 FUNERAL DIRECTOR'S SIGNATURE: Arnold A. Johnson — ADDRESS: Annapolis Md

25a. RECD BY REGISTRAR DATE: AUG 5 '60 — 25b REGISTRAR'S SIGNATURE: Arthur S. Kunes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

20632 01 X 4

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7637 — 07597

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis P.O.
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Highland Beach

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1852 - 11th Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Essie — Middle: Burrell — Last: Howley (HOWLEY)
4. DATE OF DEATH: Month: July — Day: 30 — Year: 1960

5. SEX: F — 6. COLOR OR RACE: C — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8. DATE OF BIRTH: 5/24/82 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Washington, D.C. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Burrell — 14. MOTHER'S MAIDEN NAME: Evelyn Page

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Address: Mrs Evelyn Pike (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs ?
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Eugene H. Pancheri M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED: 7/30/60

EXAMINER'S NAME (Type): EUGENE H. PANCHERI M.D. — Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/4/60 — 22c. NAME OF CEMETERY OR CREMATORY: Nat'l. Harmony Park Cem. — 22d. LOCATION (City, town, or country) (State): Maryland

23. FUNERAL DIRECTOR: [signature] — ADDRESS: 1820-9th N.W. WASH. D.C.

24a. REC'D BY REGISTRAR DATE: AUG 2 '60 — 24b. REGISTRAR'S SIGNATURE: [signature]

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7619

CERTIFICATE OF DEATH

Reg. Dist. No. 07660

1. PLACE OF DEATH
a. COUNTY HA. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvary Hos.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1017 Belvidere Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last

4. DATE OF DEATH Month JULY Day 28 Year 1960

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-17-
9. AGE (In years last birthday) 63 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT Family Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Terminal Broncho-pneumonia	24 HRS
DUE TO (b)	Massive Cerebral Hemorrhage	2 months
DUE TO (c)	Cerebral Arteriosclerosis & Hypertension	8 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 26, 1960, to July 28, 1960, that I last saw the deceased alive on July 28, 1960, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Arthur Lankford Jr. M.D.
ADDRESS (Street, city or town, state) Mountain Road
DATE SIGNED 7-28-60
PHYSICIAN'S NAME (Type) ARTHUR LANKFORD JR
Pasadena, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 7-31-60
22c. NAME OF CEMETERY OR CREMATORY Meadow Valley
22d. LOCATION (City, town, or county) (State) Millersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS

24a. REC'D BY REGISTRAR DATE JUL 29 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 67 7-28-60 ez

7638

CERTIFICATE OF DEATH

Reg. Dist. No. 07601

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1 M. 21 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1308 Linden Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Nola; Middle: ; Last: Johnson

4. DATE OF DEATH: Month: 7; Day: 21; Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 26, 1911

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William L. Thomas

14. MOTHER'S MAIDEN NAME: Eliza Burke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Pyonephrosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Carcinoma of Urinary Bladder

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ------

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY: Month, Day, Year: ----- 19 — Hour: o. m. p. m.

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 6/1 19 60 to 7/21 19 60 that I last saw the deceased alive on 7/21 19 60, and that death occurred at 6:25 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L Benedict M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 7/21/60

PHYSICIAN'S NAME (Type): L. Benedict, M. D.
Crownsville State Hospital, Md. 7/21/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/23/60
22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
22d. LOCATION (City, town, or county) (State): Catonsville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James E. O'Neill
ADDRESS: Baltimore, Md.

24a. REC'D BY REGISTRAR: DATE: JUL 25 '60
24b. REGISTRAR'S SIGNATURE: Calvin L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7596 07602

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-2, Box-67
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: F. — Last: JONES

4. DATE OF DEATH: Month: Huly — Day: 15 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 14, 1910

9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Industrial Relations

10b. KIND OF BUSINESS OR INDUSTRY: Industrial Relation

11. BIRTHPLACE (State or foreign country): Miss our$

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Charles B Jones

14. MOTHER'S MAIDEN NAME: Lena Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO:

17. INFORMANT: Dorothy Moreland Jones (2) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
(a) ACUTE HEMORRHAGIC PANCREATITIS — INTERVAL BETWEEN ONSET AND DEATH: 14 HOURS
DUE TO
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December, 1959, to July 14, 1960, that (I) (~~did~~) last saw the deceased alive on July 14, 1960, and that death occurred at 5:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward L Beck. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/15/60

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: July 18-1960

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial

23d. LOCATION (City, town, or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: Hiram M Taylor Sons

ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: JUL 18 '60

25b. REGISTRAR'S SIGNATURE: Clifton S. Knapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7597

CERTIFICATE OF DEATH

Reg. Dist. No. 0603

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 30yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 916 Smithville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 916 Smithville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isabel — Middle: Tyler — Last: Jones

4. DATE OF DEATH: Month: 7 — Day: 1 — Year: 1960

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23-1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aaron Tyler

14. MOTHER'S MAIDEN NAME: Harriett Scales

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Rosamond Steed — Address: Annapolis-Md. 916 Smithville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): 794X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 12-4-59, 19__ to 7-1-60, 19__, that I last saw the deceased alive on 6-22-60, 19__, and that death occurred at 11:12 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. J. Lee, M.D. — ADDRESS (Street, city or town, state): 61 Cathedral St. — DATE SIGNED: 7-1-60

PHYSICIAN'S NAME (Type): A J ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7-5-60

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. E. Hicks III — ADDRESS: Annapolis - Md.

24a. REC'D BY REGISTRAR DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Rivers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7598

07604

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena - Rivera Beach
d. STREET ADDRESS: 248 Wendover Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Donald; Middle: G.; Last: KENT

4. DATE OF DEATH: Month: July; Day: 31; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8, 1909

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Comfort Spring Corp.

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Kent

14. MOTHER'S MAIDEN NAME: Elizabeth Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 215-05-9456

17. INFORMANT — Address: Mrs. Louise E. Kent-248 Wendover Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ACUTE ANTERIOR MYOCARDIAL INFARTION — INTERVAL BETWEEN ONSET AND DEATH: 2 HRS.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CORONARY THROMBOSIS — 2 HRS.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 15, 1960 to July 31, 1960 that (I) (was last saw the deceased alive on July 31 1960, and that death occurred at 12:45 P.M. from the causes and on the date stated above

22a. SIGNATURE: Arthur Lankford Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-1-60

22c. PHYSICIAN'S NAME (Type): Arthur K. Lankford, Jr.

22d. ADDRESS: Mountain Road, Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/4/60

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park Cem.

23d. LOCATION (City, town or county) (State): Elkridge, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner — ADDRESS: Balto. 17, Md.

25a. REC'D BY REGISTRAR — DATE: AUG 3 '60

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7599

CERTIFICATE OF DEATH

Reg. Dist. No. 07605

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 128 Market St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 128 Market St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: A. Kramer — Last: Jr.

4. DATE OF DEATH: Month: July — Day: 14th — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 3rd 1918

9. AGE (Last birthday) 41 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Yachts

11. BIRTHPLACE (State or foreign country): Portland Oregon

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Andrew A. Kramer Sr.

14. MOTHER'S MAIDEN NAME: Mary E. Preller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWar II

16. SOCIAL SECURITY NO:

17. INFORMANT: Nancy C. Kramer (2) — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b): Malignant Hypertension — 1 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 19 59, to 7-14-, 19 60, that I lost saw the deceased alive on 7-14-, 19 60, and that death occurred at 7.45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.

ADDRESS (Street, city or town, state): 65 Main St Annapolis Md

DATE SIGNED: 7/14/60

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 16-1960

22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem.

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Gaylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: JUL 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7600 07606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 34 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL – Odenton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George Middle: Last: LARKIN
4. DATE OF DEATH: Month: July Day: 24 Year: 19 60

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 10 1897
9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Horace Larkin
14. MOTHER'S MAIDEN NAME: Nina Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-01-0940
17. INFORMANT: Garfield Larkin Address: Odenton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 3 yrs
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June 20, 19 60 to July 23, 19 60, that (I) (~~was~~) last saw the deceased alive on July 23, 19 60, and that death occurred at 6:45 A.M. from the causes and on the date stated above.

22a SIGNATURE: Edward S. Beck M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 7/25/60
22c. PHYSICIAN'S NAME (Type): Edward S. Beck
22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, ~~CREMATION~~ REMOVAL (Specify)
23b. DATE THEREOF: July 27/60
23c. NAME OF CEMETERY OR CREMATORY: Faulks
23d LOCATION (City, town, or county) (State): Odenton A.A. Md

24 FUNERAL DIRECTOR'S SIGNATURE: Hamil A. Johnson ADDRESS: Annapolis
25a RECD BY REGISTRAR DATE: JUL 27 '60
25b. REGISTRAR'S SIGNATURE: Collins S. Kraus

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7601 Reg. Dist. No. 07607

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: Highland Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry — Middle P. — Last Lebelle

4. DATE OF DEATH: Month July — Day 8 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 22, 1909

9. AGE (In years last birthday): 37 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Research Analysis

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul Lebelle

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Lucille M. Lebelle — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: DOA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Artery Disease — 3 yr.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to 7-8-60, that I last saw the deceased alive on 7-6-60, 19__, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M Shipley, M D — ADDRESS (Street, city or town, state): 124 Cathedral St — DATE SIGNED: 7-8-60

PHYSICIAN'S NAME (Type): Frank M Shipley — Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: July 11, 1960

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

22d. LOCATION (City, town, or county) (State): Bladensburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur S Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7602 — 07608

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Ann e Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Davidsonville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: RAY — Last: LONG

4. DATE OF DEATH: Month: July — Day: 4 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 21, 1892

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationery Fireman

10b. KIND OF BUSINESS OR INDUSTRY: US Gov

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Henry Long

14. MOTHER'S MAIDEN NAME: Arabella Sands

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 205-03-1365

17. INFORMANT: Mae M. Long- wife- same as # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO (b): Pulmonary embolus — 1 mo
DUE TO (c): Carcinoma of Bladder — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

191.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: — o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 4, 1960 to July 4, 1960, that (I) (~~this~~ last saw the deceased alive on July 4, 1960, and that death occurred at 9:20P. M, from the causes and on the date stated above

22a. SIGNATURE: Edwin Davis, Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7-4-60

22c. PHYSICIAN'S NAME (Type): Edwin Davis, Dr.

22d. ADDRESS: 98 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 8, 1960

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Home Annapolis, Md.

25a. RECD BY REGISTRAR DATE: JUL 11 '60

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7639

CERTIFICATE OF DEATH

Reg. Dist. No. 07609

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkerton mano, 33
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Manor Rd.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md
b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkerton (Laurel mano)
d. STREET ADDRESS Severna Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Isaac Middle Winfield Last Machen
4. DATE OF DEATH Month 7 Day 28 Year 60 19.
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 15, 1883
9. AGE (In years last birthday) 77 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Honest
11. BIRTHPLACE (State or foreign country) United States
12. CITIZEN OF WHAT COUNTRY U. S.

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Son Winfield H. Machen Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Hypertensive Cardiovascular
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1956, 19____, to 7-26-60, 19____, that I last saw the deceased alive on 7-27-60 19____, and that death occurred at 1:30 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Robert P. Hahn M.D. ADDRESS (Street, city or town, state) Severna Park DATE SIGNED 7-28-60
PHYSICIAN'S NAME (Type) Robert P. Hahn died

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-1-60
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem
22d. LOCATION (City, town, or county) Glen Burnie (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Benson ADDRESS Severn Park
24a. REC'D BY REGISTRAR DATE AUG 3 '60
24b. REGISTRAR'S SIGNATURE Charles S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7603

CERTIFICATE OF DEATH

Reg. Dist. No. 07610

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 923 Jackson Street

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis,
d. STREET ADDRESS: 1208 Bay Ridge Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henretta — Middle: G — Last: Masters

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 18, 1884
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Deale, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Philmore W. Windsor
14. MOTHER'S MAIDEN NAME: Henretta Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no / no
16. SOCIAL SECURITY NO.: none
INFORMANT: Mr. George J. Masters- Son- Jackson, St. Mi.
Address: Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Pulmonary Edema
DUE TO (b): Arteriosclerotic C.V.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 1 d. / yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity, Bronchial asthma, arthritis
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour a m / p m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ~~19~~ 7-5-60 to 7-6-60, that I last saw the deceased alive on 7-5-60, 19, and that death occurred at 2 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank M. Shirley M.D
ADDRESS (Street, city or town, state): 12 Cathedral St
DATE SIGNED: 7-8-60
PHYSICIAN'S NAME (Type): Frank Shirley MD
Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 9, 1960
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopkins Funeral Home
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR DATE JUL 11 '60
24b. REGISTRAR'S SIGNATURE: Clothus S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 ... 6-8-60 et

7640

CERTIFICATE OF DEATH

07611

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIDSONVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X DAVIDSONVILLE
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Lidwina — Middle: — Last: Mayr

4. DATE OF DEATH: Month: July — Day: 31 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1873

9. AGE (If years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clemank Greisl

14. MOTHER'S MAIDEN NAME: (Unknown) Brugger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Thomas E. Mayr- Son- Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Arteriosclerotic cardiovascular
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): disease and senility — Several years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 3-2, 1960, to July 31, 1960, that I last saw the deceased alive on July 31, 1960, and that death occurred at 10:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Linn M.D. — ADDRESS (Street, city or town, state): RFD #1 Box 271-M — DATE SIGNED: 7-31-60

PHYSICIAN'S NAME (Type): Sylvia M. Linn — Edgewater Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 3, 60

22c. NAME OF CEMETERY OR CREMATORY: Our Lady of Sorrows

22d. LOCATION (City, town, or county) (State): Owensville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: AUG 4 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7641

CERTIFICATE OF DEATH

Reg. Dist. No. 07612

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Howard~~ Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 212-A Gorman Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle BLAIN — Last METCALF

4. DATE OF DEATH: Month July — Day 25 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ N/A DIVORCED ☐

8. DATE OF BIRTH: 15 July 60

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days 10 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Llewellyn Metcalf

14. MOTHER'S MAIDEN NAME: Romana Swift

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

INFORMANT: Father — Address: 212 A Gorman Rd Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH: Since Birth

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Subarachnoid and intraventricular hemorrhage — recent
DUE TO
(c): — moderate

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 15 July, 19 60, to 25 July, 19 60, that I last saw the deceased alive on 25 July, 19 60, and that death occurred at 9:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur H. Miller M.D — ADDRESS (Street, city or town, state): USA Hosp Ft Geo G Meale, Md — DATE SIGNED: 25 July 60

PHYSICIAN'S NAME (Type): WILBUR H. MILLER, JR., Capt., M.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: 7-27-60
22c NAME OF CEMETERY OR CREMATORY: ULYSSES CEM.
22d. LOCATION (City, town, or county) (State): ULYSSES, PA.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

24a. REC'D BY REGISTRAR DATE JUL 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO BE FILLED OUT BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7642 CERTIFICATE OF DEATH

Reg. Dist. No. 07613

1. PLACE OF DEATH a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owens Beach
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R F D # 1 Deale Md

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt Rainier Md.
d. STREET ADDRESS: 3828 34th st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle Elizabeth — Last Miller
4. DATE OF DEATH: Month July — Day 13 — Year 1960
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 27, 1863
9. AGE (In years last birthday): 96 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY: U S A

13. FATHER'S NAME: Kennedy Evans
14. MOTHER'S MAIDEN NAME: Nancy Crumb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Lucy Bon Durant Mt Rainier Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary insufficiency — 20 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 12 July, 1960, to 13 July, 1960, that I last saw the deceased alive on 13 July, 1960, and that death occurred at 11.40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R B Sasser M.D. — ADDRESS (Street, city or town, State): Upper Marlboro, Md — DATE SIGNED: 13 July 60

PHYSICIAN'S NAME (Type): R B Sasser — R B Sasser — Upper Marlboro Md.

22a. BUR A., CREMATION, REMOVAL (Specify): Burial, Removal
22b. DATE THEREOF: 7/16/60
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chaple Cemetery
22d. LOCATION (City, town, or county) (State): Newcomerstown, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons Hyattsville, Md.
24a. REC'D BY REGISTRAR — DATE: JUL 18 '60
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7643

CERTIFICATE OF DEATH

07614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 9/59

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cedar Heights
d. STREET ADDRESS: 6407 Kolb Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Rosa — Middle: — Last: Miller

4. DATE OF DEATH: Month: July — Day: 4 — Year: 1960

5 SEX: Female

6 COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 5-10-1893

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): Unknown

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: Mrs. Wesley-D.P.W.-Prince George Co.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General debility and decubitus ulcers.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June 25, 1960 to July 4, 1960, that (I) (was) last saw the ~~deceased~~ alive on July 2, 1960, and that death occurred at 3A M. from the causes and on the date stated above.

22a SIGNATURE: James M. Pair M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: July 4,1960

22c PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22d ADDRESS: 400 N. Carrollton Avenue Balto.23,Md.

23a BURIAL, CREMATION, REMOVAL (Specify): (Burial)

23b. DATE THEREOF: 7-7-60

23c NAME OF CEMETERY OR CREMATORY: St Marys Ch. Cem

23d LOCATION (City, town, or county) (State): Groom Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Henry S Washington & Son
4925 - Dix Ave N.E.

25a REC'D BY REGISTRAR DATE: JUL 8 '60

25b REGISTRAR'S SIGNATURE: Clifton T. Perkins

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7604 — 07615 — Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A. A. — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland b. COUNTY: A. A.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General Hospital — d. STREET ADDRESS: 79 Spa Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Anthony — Middle: — Last: Molbrey
4. DATE OF DEATH: Month: 7 — Day: 6 — Year: 1960
5. SEX: Male — 6. COLOR OR RACE: Col — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 2-7-1960 — 9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Charles Molbrey — 14. MOTHER'S MAIDEN NAME: Mary Clendenin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mary Clendenin — Address: 79 Spa Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Instan.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
724.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Child drowned in fish pond
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: 7-6-1960 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☒ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: F Linhardt — ___ M.D — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7-6-60
EXAMINER'S NAME (Type): F Linhardt.

22a. BURIAL CREMATION REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7-8-1960 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill — 22d. LOCATION (City, town, or county) (State): Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE: William Reese — ADDRESS: Annapolis Md — 24a. RECD BY REGISTRAR DATE: JUL 14 '60 — 24b. REGISTRAR'S SIGNATURE: Cuthbert L. Evans

203918 IxV4

TO DEALER MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please explain. Complete certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the chief medical examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
8M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7644 **CERTIFICATE OF DEATH** Reg. Dist. No. 07616

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2 yrs. 7 mo. 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmount
d. STREET ADDRESS: 802-58th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: S. — Last: Nichols

4. DATE OF DEATH: Month: 7 — Day: 5 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 2, 1876

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert S. Nichols

14. MOTHER'S MAIDEN NAME: Amanda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Brain Syndrome Associated with Senile Brain Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): -------

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. ----- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------

20f. (City or town) (County) (State): -------

21. I certify that I attended the deceased from 11/19 1957 to 7/5 1960, that I last saw the deceased alive on 7/5 1960, and that death occurred at 8:00A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 7/5/60

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 7/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/9/60

22c. NAME OF CEMETERY OR CREMATORY: Nat'l. Harmony Mem.

22d. LOCATION (City, town, or county) (State): Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert F. McGuire — ADDRESS: 1820-7th St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR DATE: JUL 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7645

Reg. Dist. No. 07617

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 604 W. Fayette Street 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth Middle Last Parker

4. DATE OF DEATH: Month July Day 25 Year 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1864

9. AGE (In years last birthday): 96 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Rainey-Baltimore D.P.W. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease with — INTERVAL BETWEEN ONSET AND DEATH: Many yrs.

DUE TO: chronic brain syndrome.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 8, 1960, to July 25, 1960, that I last saw the deceased alive on July 23, 1960, and that death occurred at 3 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James M. Pair M.D.
ADDRESS (Street, city or town, state): 400 N. Carrollton Avenue Baltimore 23, Maryland
DATE SIGNED: 7-25-1960

PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-27-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles R. Law
ADDRESS: 802 Madison Ave.

24a. REC'D BY REGISTRAR DATE: JUL 27 '60
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7605

CERTIFICATE OF DEATH

07618

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elvaton
d. STREET ADDRESS: 363 Brookwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: F — Last: PERINA, Sr.

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1900

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Packer GH Hardware

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alex Perina

14. MOTHER'S MAIDEN NAME: Nichle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-01-9826

17. INFORMANT: Edward Perina JR — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 d

DUE TO (b): Coronary artery Disease — ?

DUE TO (c): + Pericarditis — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 2, 1960 to July 5, 1960, that (I) (we) last saw the deceased alive on July 5, 1960, and that death occurred at 2:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M. Shipley M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 7/6/60

22c. PHYSICIAN'S NAME (Type): Frank M. Shipley

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 8-60

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

23d. LOCATION (City, town, or county) (State): Glen Burnie Md

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard A Fink — ADDRESS: Glen Burnie Md

25a. REC'D BY REGISTRAR DATE: JUL 8 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7646 — Reg. Dist. No. 07619

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Lurnie
c. LENGTH OF STAY IN 1b: 10 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 601 Sixth Ave and Ritchie Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Baltimore~~/~~25~~ -A.A. ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~3504 Fourth Street~~ Baltimore 5
d. STREET ADDRESS: 3504 Fourth Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Elmoden Middle Last Pitcock
4. DATE OF DEATH: Month July Day 18th. Year 19 60
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/28/14
9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Winchester, Va.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Elmoden ~~Pit~~ Pitcock
14. MOTHER'S MAIDEN NAME: Edna Avery
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown). If yes, give war or dates of service: Yes (Marines) 1943
16. SOCIAL SECURITY NO.: 066-14-4399
17. INFORMANT — Address: Mrs. Nora Pitcock

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): 420.1
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 7/18/60
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/21/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hebron Cemetery
22d. LOCATION (City, town, or county) (State): Winchester, Va.
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR — DATE JUL 19 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7647 — 07620 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundle — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 4 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 218 Wicklow Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rose — Middle: Lee — Last: Ramsburg
4. DATE OF DEATH: Month: 7 — Day: 20 — Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/29/08 1867
9. AGE (In years last birthday): 92 yrs. 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Louden Co., Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Schaefer
14. MOTHER'S MAIDEN NAME: Darcus Jane ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Address: Mrs. Lucy Lahan (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
I 20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave E. Faubert M.D. — M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7/20/60
EXAMINER'S NAME (Type): Gustave E. Faubert M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify):
22b. DATE THEREOF: 7-23-60
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
22d. LOCATION (City, town, or county) (State): Baltimore MD

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: [illegible]
24a. REC'D BY REGISTRAR DATE: JUL 22 '60
24b. REGISTRAR'S SIGNATURE: Clinton L. Kuna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form EM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7648

07621 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle David Last Rice

4. DATE OF DEATH: Month July Day 27 Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 18, 1914

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William John Rice

14. MOTHER'S MAIDEN NAME: Clara F. Donaldson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Jessie Rice, Same as 2 (Address)

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suicide by voluntary inhalation of carbon

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): monoxide
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): By connecting one end of rubber hose to ~~exhaust~~ exhaust pipe and the other end to the front seat

20c. TIME OF INJURY: Hour Unknown a. m. p. m. Month, Day, Year 7/27/60 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hog Road

20f. (City or town) Millersville, (County) A.A. Co. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTIVE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible]ral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO D[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please [illegible] certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible]ral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ACTUAL SIGNATURE: Gustave H. Faubert-MD ___ M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/27/60

[illegible] NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 30 1960

22c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial

22d. LOCATION (City, town, or county): Millersville, AA Co. (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping and Kirkley, Glen Burnie, Md. (ADDRESS)

24a. REC'D BY REGISTRAR DATE: JUL 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7649

Reg. Dist. No. 07622

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 5yrs. 6mos.
d. NAME OF HOSP.TAL (If not in hospital, give street address OR INSTITUTION): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glencoe
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Ringgold

4. DATE OF DEATH: Month: July — Day: 1 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/12/28

9. AGE (In years last birthday): 32 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Ringgold

14. MOTHER'S MAIDEN NAME: Amelia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk

INFORMANT: Hospital records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 17, 1954, to July 1, 1960, that I last saw the deceased alive on July 1, 1960, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: Carl E. Kirk M.D

PHYSICIAN'S NAME (Type): Carl B Schleifer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-6-60

22c. NAME OF CEMETERY OR CREMATORY: Stevenson Cem.

22d. LOCATION (City, town, or county) (State): Sparks Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Jackson Funeral Home [illegible]

24a. REC'D BY REGISTRAR — DATE: JUL 6 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7650

CERTIFICATE OF DEATH

07623
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade
c. LENGTH OF STAY IN 1b: 27 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admiss on)
a. STATE: Maryland
b. COUNTY: Pr. Geo. ✓
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 9 Laurel Mannor, Apt 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: — Last: Robinson

4. DATE OF DEATH: Month: July — Day: 1 — Year: 19 60

5. SEX: MALE
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 30 Jun 1960
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: 27 — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John R. Robinson
14. MOTHER'S MAIDEN NAME: Gladys Ann Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N/A (If yes, give war or dates of service): N/A
16. SOCIAL SECURITY NO.: N/A
INFORMANT Address: Mrs. Cladys Robinson, 9 Laurel Mannor, Laurel Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH:
: 13.5
DUE TO
(b): Immaturity — Since birth
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 30 June, 19 60 to 1 July, 1960, that I last saw the deceased alive on 1 July, 19 60; and that death occurred at 0845AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Wilbur H. Miller Jr. M.D. — 1 July 60

PHYSICIAN'S NAME (Type): WILBUR H. MILLER, JR., Capt, MC, U.S. Army Hospital, Ft Geo G. Meade, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 3, 1960
22c. NAME OF CEMETERY OR CREMATORY: Savage Cemetery
22d. LOCATION (City, town, or county) (State): Savage Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: DeWitt Donaldson, Laurel, Md.
24a. REC'D BY REGISTRAR DATE: JUL 8 '60
24b. REGISTRAR'S SIGNATURE: Caroline S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2-C-7203 XV1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7651 Item 8 Film 2218 8-2-60 et

07624 Reg. Dist. No.

FOR STATE HEALTH DEPT.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Heights
c LENGTH OF STAY IN 1b: 13 years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 923 Victory Avenue

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Same — b COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle John — Last Roche
4. DATE OF DEATH: Month July — Day 21st. — Year 1960

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 8/7/86
9 AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Edna Gertrude Roche (wife) — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21, I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave K. Faubert — M.D — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 7/21/60

NAME (Type): Gustave K. Faubert, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): X
22b DATE THEREOF: 7-25-60
22c. NAME OF CEMETERY OR CREMATORY: Crematorium
22d LOCATION (City, town, or county) (State): Dundalk

23. FUNERAL DIRECTOR'S SIGNATURE: Kelly — ADDRESS: 305 Fairfield Ave.

24a. REC'D BY REGISTRAR DATE: JUL 27 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinsel

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the items is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the chief medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7652

CERTIFICATE OF DEATH

07625
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, ANNAPOLIS
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BELVOIR, CROWNSVILLE, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MD
b. COUNTY: N. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, RURAL
d STREET ADDRESS: BELVOIR, CROWNSVILLE, MD.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MARGARET Middle BRYAN Last ROGERS

4. DATE OF DEATH: Month 7 Day 18 Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 21-1886

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): WASHINGTON D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SAMUEL BRYAN

14. MOTHER'S MAIDEN NAME: MARGARET BEMIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Cortlandt C. Rogers — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: MINUTES.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC AND HYPERTENSIVE
DUE TO (c): VASCULAR DISEASE — 2 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ____ o. m. p. m. Month ____ Day ____ Year 19____

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/27/, 1957, to 7/18, 1960, that I last saw the deceased alive on 6/7, 1960, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Pleler M.D. — ADDRESS (Street, city or town, state): 121 CATHEDRAL ST. — DATE SIGNED: 7/18/60

PHYSICIAN'S NAME (Type): RICHARD N PLELER — ANNAPOLIS,

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7-21-60

22c. NAME OF CEMETERY OR CREMATORY: ST. ANNES

22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: JUL 21 '60

24b. REGISTRAR'S SIGNATURE: Carlton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7620

CERTIFICATE OF DEATH

Reg. Dist. No. 07626

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riviera Beach
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3804 Biddison Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mr. Thomas; Middle:; Last: Romagni

4. DATE OF DEATH: Month: July; Day: 22nd; Year: 1960

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 13, 1896

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Guy Romagni

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 218-28-0300

INFORMANT: Mrs. Lena Romagni, Address: 3804 Biddison Lane.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
DUE TO
(b): Arteriosclerosis — ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1953, to 7-22, 1960, that I last saw the deceased alive on 7-6, 1960, and that death occurred at 10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. A. Sussman M.D. ADDRESS (Street, city or town, state): 3101 N. Charles St DATE SIGNED: 7-23-60

PHYSICIAN'S NAME (Type): A. A. SUSSMAN Balto 18, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/27/60

22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leonard J. Ruck 5305 Harford Road #14

24a. REC'D BY REGISTRAR DATE: JUL 25 '60

24b. REGISTRAR'S SIGNATURE: Arthur J. Mitchell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07627

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A. A. CO.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIDSONVILLE

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. GENERAL HOSPITAL

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Otto — Middle: H. — Last: ROSSBACK

4. DATE OF DEATH: Month: 7 — Day: 6 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11-5-1895

9. AGE (If over 100 years, last birthday): 64 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SAW MILL Operator

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER

11. BIRTHPLACE (State or foreign country): WISCONSIN

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: EDWARD ROSSBACK

14. MOTHER'S MAIDEN NAME: AMELIA Unknow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS OLIVE ROSSBACK — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): [illegible]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 7-6-60

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7-9-60

22c. NAME OF CEMETERY OR CREMATORY: HILLCREST

22d. LOCATION (City, town, or county) (State): ANNAPOLIS MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7653

CERTIFICATE OF DEATH

Reg. Dist. No. 07628

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 32 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 902 Crain Highway NW

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 902 Crain Hghy, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: Augusta — Last: Ruby

4. DATE OF DEATH: Month: July — Day: 7 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 3, 1894

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theodore Metzke

14. MOTHER'S MAIDEN NAME: Pauline Dalhke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: ---------

17. INFORMANT — Address: Mr. William W. Ruby, same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b): Coronary Artery Disease — 2-3 y.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Hypretensive Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7.5. , 1960, to 7.7.60. , 19 , that I last saw the deceased alive on 7.5. , 1960, and that death occurred at 10.00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew Szabo M.D. — ADDRESS (Street, city or town, state): 3 Crain Highway Glen Burnie, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Andrew K. Szabo, M.D. — 3 Crain Highway SE, Glen Burnie

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/12/60

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James A. Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR: DATE: JUL 12 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death: Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7654

07629

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: 2 weeks
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ridgewood Manor

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: ✓
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 1445 Andre St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adolph — Middle: — Last: Schmidt

4. DATE OF DEATH: Month: 7 — Day: 16 — Year: 60

5 SEX: Male

6 COLOR OR RACE: Wht.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: March 18 - 1884

9 AGE (In years last birthday): 24 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bigger & Carpenter

10b KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Un Known

14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-07-4155

17 INFORMANT — Address: August Schmidt 1445 Andre St.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Infarct with Coma. — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Chronic Nephritis — 2 years

DUE TO (c): Cardiac & Renal Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Paralysis, Resected. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 7/3/60 19 to 7/16/60 19, that (I) (we) last saw the deceased alive on 7/13/60, and that death occurred at 7 P.M. from the causes and on the date stated above

22a SIGNATURE: Joseph Lipskey M.D — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 7/16/60

22c PHYSICIAN'S NAME (Type): JOSEPH LIPSKEY

22d ADDRESS: ODENTON MD

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-19-60

23c NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

23d LOCATION (City, town, or county) (State): Anne Arundel, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles L Stevens Funeral Home, Inc.

ADDRESS: 1501 E. Fort Ave

25a REC'D BY REG STRAR DATE JUL 18 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7655

CERTIFICATE OF DEATH

Reg. Dist. No. 07630

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
c. LENGTH OF STAY IN 1b 2yrs
d NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION Rt. 1 - Box 254 B - Hunter's Harbor

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena
d. STREET ADDRESS Rt. 1 - Box 254 B Hunters Harbor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Naomi Middle Last SCOTT

4. DATE OF DEATH Month July Day 12 Year 19 60

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 15 Sept. 1911
9. AGE (In years last birthday) 48 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (ret.)
10b. KIND OF BUSINESS OR INDUSTRY Murphy's 5-10-25¢ Store
11. BIRTHPLACE (State or foreign country) Balto., Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Curray
14. MOTHER'S MAIDEN NAME Bertha (unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO 212-01-3345
INFORMANT Mr. Wm. G. Scott, Jr. Address Same As #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 5 days

757.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Polycystic kidneys, bilateral — Congenital

DUE TO (c) Nyocarditis — 6 mo.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible] that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above

ACTUAL SIGNATURE Francis I. Judd M.D

ADDRESS (Street, city or town, state) Severna Park, Maryland

DATE SIGNED 7-13-60

PHYSICIAN'S NAME (Type) Francis I. Judd

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 16th July 1960
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] Completion
ADDRESS Glen Burnie Md.

24a REC'D BY REGISTRAR DATE JUL 18 '60
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7656

Reg. Dist. No. 07631

1. PLACE OF DEATH
a. COUNTY: Howard — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Dunn Mortuary Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: A. Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crambills P.O.
d. STREET ADDRESS: Box 7
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Helen — Middle: — Last: Letts

4. DATE OF DEATH: Month: 7 — Day: 1 — Year: 1960

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 6-1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Self Employ

11. BIRTHPLACE (State or foreign country): Sayre Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Stevenson

14. MOTHER'S MAIDEN NAME: Annie Birch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Helen Sterritt — Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): with decompensation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Generalized Edema a Chronic Hypertensive Condition

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME ~~OF INJURY~~ Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or Town) (County) (State)

21. I certify that I attended the deceased from 2/8/60 19__ to 7/1 19__, that I last saw the deceased alive on 6/30/60 19__, and that death occurred at 12:24 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph Lipsky M.D.
ADDRESS (Street, city or town, state): Glen Burnie Md
DATE SIGNED

PHYSICIAN'S NAME (Type): JOSEPH LIPSKY

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/3/1960
22c. NAME OF CEMETERY OR CREMATORY: St. Stephens Ch. Cemetery
22d. LOCATION (City, town, or county) (State): Crownsville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Dunn Funeral Home
ADDRESS: Glen Burnie
Robert E. Dunn

24a. REC'D BY REGISTRAR DATE: JUL 5 60
24b. REGISTRAR'S SIGNATURE: Arthur A. Munns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7607 — 07632

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 57 Northwest St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: — Last: SIMMS

4. DATE OF DEATH: Month: July — Day: 27 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1897

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: *******

11. BIRTHPLACE (State or foreign country): Maryland - Annapolis

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: George Clark

14. MOTHER'S MAIDEN NAME: Eliza Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 213-16-1065

17. INFORMANT: Florence Benson — Address: Severna Park P.O. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Partial obstruction of left main bronchus, — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
163X
DUE TO: Superior Vena Cava & Esophagus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Carcinoma, right lung — 5 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a m / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1960 to July 27, 1960, that (I) (~~saw~~) last saw the deceased alive on July 27, 1960, and that death occurred at 9:45P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. L. Richardson M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/28/60

22c. PHYSICIAN'S NAME (Type): R. L. Richardson

22d. ADDRESS: 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 30-60

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town, or county) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR — DATE: AUG 1 '60

25b. REGISTRAR'S SIGNATURE: Cathrine L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8780 **CERTIFICATE OF DEATH** 08756

1 **PLACE OF DEATH**
a COUNTY: Anne Arundel
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c LENGTH OF STAY IN 1b: 6mo. 11 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b COUNTY: Baltimore
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1840 N. Caroline Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Eva; Middle: ; Last: Smith

4. **DATE OF DEATH**: Month: 7; Day: 30; Year: 1960

5 SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

8 DATE OF BIRTH: 1910

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b KIND OF BUSINESS OR INDUSTRY: ---

11 BIRTHPLACE (State or foreign country): North Carolina

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service):

16 SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Hypertensive Arteriosclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe Mental Deficiency

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ---

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. ----- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f (City or town) (County) (State): ---

21 **I certify** that (I) (this hospital) attended the deceased from 1/19 19 60 to 7/30 19 60 that (I) (we) last saw the deceased alive on 7/30 19 60, and that death occurred at 11:15 p.m. from the causes and on the date stated above

22a SIGNATURE: [signature] M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 8/1/60

22c. PHYSICIAN'S NAME (Type): Hildegard H. Reissmann, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a BURIAL CREMATION Other (Specify): Burial

23b DATE THEREOF: 8/4/60

23c. NAME OF CEMETERY OR CREMATORY: Anty of Maryland

23d LOCATION (City, twp, or county): Baltimore (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: William Russell

ADDRESS: 108 W. Washington St

25a. REC'D BY REGISTRAR DATE: 8/4/60

25b REGISTRAR'S SIGNATURE: [signature]

AUG 8 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7657 Items 7,8,9,11,a,b,c & d Film G267 7/14/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 07633

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville Md.
c. LENGTH OF STAY IN 1b: 13 Months
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Md.
d. STREET ADDRESS: 4207 Flyers Mills Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Joshua Middle — Last SMOTHERS

4. DATE OF DEATH: Month 7 Day 4 Year 19 60

5 SEX: M

6. COLOR OR RACE: N.

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 4 1894 ? 1889 ?

9 AGE (In years last birthday): 71 yrs 65

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses Smothers

14. MOTHER'S MAIDEN NAME: Victoria Payne

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyperpyrexia
DUE TO (b): Cerebral Thrombosis
DUE TO (c): Syphilis of the Central Nervous System.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b): Hypostatic Pneumonia Epilepsy C.B.S. due to CNS Syphilis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day, Year Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on July 4, 19 60, and that death occurred at 5:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Crownsville State Hospital

DATE SIGNED: 7/4/60

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp M.D.

Crownsville, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 7, 1960

22c NAME OF CEMETERY OR CREMATORY: Ash Memorial

22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Robert C. Amerman

ADDRESS: Rockville Md.

24a. REC'D BY REGISTRAR DATE: JUL 11 60

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7608

07634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: A. A.
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 19 Mabell Ave.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md.
d. STREET ADDRESS: 19 Mabell Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: W. Last: Sorrell

4. DATE OF DEATH: Month: 7 Day: 11 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-1-1883

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Sorrell

14. MOTHER'S MAIDEN NAME: Josephine Sorrell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT, Address: Marion Howard 19 Mabell Ave.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia / Stomach — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 4-6-60 19___, to 7-11-60 19___, that (I) (we) last saw the deceased alive on 7-10-60 19___, and that death occurred at ____M, from the causes and on the date stated above

22a. SIGNATURE: T. Allen M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): T T ALLEN

22d ADDRESS: 62 Cathedral St

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 7-14-1960

23c NAME OF CEMETERY OR CREMATORY: Graveyard

23d LOCATION (City, town, or county) (State): Churchton Md.

24) FUNERAL DIRECTOR'S SIGNATURE: William Reese

ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: JUL 14 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Evans

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7609 — Reg. Dist. No. 07635

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GEN. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GLEN BURNIE
d. STREET ADDRESS: 302 7th AV. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELSIE — Middle H. — Last (SOUTAR) SOUTAR
4. DATE OF DEATH: Month July — Day 24 — Year 1960
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/31/99
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? Scotland

13. FATHER'S NAME: James A. Watson
14. MOTHER'S MAIDEN NAME: Helen Cunningham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days +
DUE TO (b): Ac. & Ch. Pyelo Nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Re. Myocardial Infarction; Chronic Alcoholism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/2/, 1960 to 7/24/, 1960 that I last saw the deceased alive on 7/24, 1960, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: Maurice K. Lawrence M.D. — ADDRESS (Street, city or town, state): 31 South Prince St., Annapolis, Md. — DATE SIGNED: 7/24/60
PHYSICIAN'S NAME (Type): MAURICE F. KLAWANS, Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-28-60
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook, Inc., 1217 St. Paul Street
24a. REC'D BY REGISTRAR DATE: JUL 26 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

7658 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07636

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 W. First Ave.
c. LENGTH OF STAY IN 1b: 33yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooklyn Park

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] rural - Baltimore
d. STREET ADDRESS: 17 W. First Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amelia — Middle: Margaret — Last: Spiegel

4. DATE OF DEATH: Month: July — Day: 14 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-8-1880

9. AGE (In years last birthday): 80 yrs
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: August Tribull

14. MOTHER'S MAIDEN NAME: Anna Dan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. August Spiegel, 200 Phelps Ave. Address: Glen Burnie, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12/18/58 to 2/14/60 that (I) (we) last saw the deceased alive on 2-14-1960, and that death occurred at 5:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Morton M. Krieger M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/14/60

22c. PHYSICIAN'S NAME (Type): Morton M. Krieger

22d. ADDRESS: 501A Ritchie Highway 25

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 7-16-1960
23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: George J. Gonce - 4001 Ritchie Hgwy. (25)
George J. Gonce

25a. RECEIVED BY REGISTRAR DATE: JUL 18 60
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07637

7610 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS, MARYLAND
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HIGHVIEW-ON-THE-BAY, TRACY'S LANDING,
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: ELLSWORTH — Last: Stine, SR.
4. DATE OF DEATH: Month: July — Day: 9 — Year: 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 11, 1900
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Director of Money Orders
10b KIND OF BUSINESS OR INDUSTRY: U.S.Govt.-P.O. Dept.
11 BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Stine
14 MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: none
17 INFORMANT — Address: Mr. Harry E. Stine, Jr., 10,217 Ridgemoor Dr., S.S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Scleraderma — at least 18 months
DUE TO (c):
710.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 5, 1960 to July 9, 1960, that I last saw the deceased alive on July 9, 1960, and that death occurred at 2:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard F. Smith M.D. — ADDRESS (Street, city or town, state): Shady Side, Md — DATE SIGNED: 7/9/60
PHYSICIAN'S NAME (Type): WILLARD F. SMITH, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: July 13, 1960
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d LOCATION (City town or county) (State): MONTGOMERY COUNTY, MARYLAND

23 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — ADDRESS: WARNER E. PUMPHREY, INC., SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: JUL 14 60
24b REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7659

07638

1. PLACE OF DEATH
a. COUNTY A. A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Emma Middle Lost Saylor

4. DATE OF DEATH Month 7 Day 13 Year 1960

5 SEX Female

6 COLOR OR RACE Col

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH 2-12-1894

9 AGE (In years last birthday) 66 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Samuel Butler

14. MOTHER'S MAIDEN NAME Luvenia Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Ada Thomas Address Mayo Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease - Uremia

393X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Congestive Failure

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from HL-60, 19__ to 7-13-60, that (I) (we) last saw the deceased alive on 7-12-60, and that death occurred at 5 A.M., from the causes and on the date stated above.

22a SIGNATURE A T Allen M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type) A T ALLEN

22d ADDRESS 614 Cathedral St

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b DATE THEREOF 7-17-60

23c NAME OF CEMETERY OR CREMATORY Hope Chapel

23d LOCATION (City, town, or county) Edgewater (State) Md.

24 FUNERAL DIRECTOR'S SIGNATURE William Reese Jr. ADDRESS Annapolis Md.

25a. REC'D BY REGISTRAR DATE JUL 22 '60

25b REGISTRAR'S SIGNATURE Christine S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07639

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
STREET ADDRESS: 113 Melbourne Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LESLIE — Middle: M. — Last: THOMPSON

4. DATE OF DEATH: Month: July — Day: 27 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-25-99

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Manager

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William M. Thompson

14. MOTHER'S MAIDEN NAME: Nannie Downs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.: 578-07-2705

17. INFORMANT: Dorothy B. Thompson — Address: Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemopericardium with cardiac tamponade
DUE TO (b): Rupture of dissecting aneurysm of ascending aorta
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Partial

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Partial

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐.

ACTUAL SIGNATURE: W. Bradley King, Jr., M.D.

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

DATE SIGNED: 7/27/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-30-60

22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR, ADDRESS: F. J. Collins 3821-14th N.W. D.C.

24a. REC'D BY REGISTRAR DATE: AUG 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07640

1. PLACE OF DEATH
a. COUNTY: P.G. CO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.C.G. Hosp. Hospital Gen

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: MD — b. COUNTY: PGCO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seven Oaks Est. LD
d. STREET ADDRESS: Dill RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle H — Last Todd
4. DATE OF DEATH: Month 7 — Day 16 — Year 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-7-43
9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS H TODD, SR.
14. MOTHER'S MAIDEN NAME: ELIZABETH SHERIDAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Electrocution — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Touching an metal lamp electric cord
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year: 7-16 60
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-16 60
EXAMINER'S NAME (Type): E Lin Hargett

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/19/60
22c. NAME OF CEMETERY OR CREMATORY: Maryland Park
22d. LOCATION (City, town, or county) (State): Parkville Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Barranco
ADDRESS: Severna Park Md.
24a. REC'D BY REGISTRAR — DATE FILED: JUL 25 '60
24b. REGISTRAR'S SIGNATURE: Collins L. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form EM3. Page [illegible] may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AT5ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

7613 — Reg. Dist. No. 07641

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 38 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible], Annapolis, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 13
d. STREET ADDRESS: 9 German Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emanual — Middle: Joseph — Last: TOPLE

4. DATE OF DEATH: Month: July — Day: 15 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-25-1882

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. NAVY

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - - - -

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank TOPLE

14. MOTHER'S MAIDEN NAME: Katherine SMIECINA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1917-1922

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Wife-Faith C. TOPLE, 9 German Street, Annapolis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma Prostate with Metastases — INTERVAL BETWEEN ONSET AND DEATH: Unknown

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25th, 1960, to July 15th, 1960, that I last saw the deceased alive on July 15th, 1960, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. C. Laning, M.D. — ADDRESS (Street, city or town, state): USNH, Annapolis, Maryland — DATE SIGNED: 7-15-60

NAME (Type): R. C. LANING — 7-15-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 19th 1960

22c. NAME OF CEMETERY OR CREMATORY: Annapolis National

22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: JUL 18 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/S

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7660

CERTIFICATE OF DEATH

07642

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Central Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davidsonville
d. STREET ADDRESS: Central Ave.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ERNEST Middle DERUNDEL Last TUCKER

4. DATE OF DEATH: Month July Day 11 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 5, 1878
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ref. Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Road Maintance
11. BIRTHPLACE (State or foreign country): Davidsonville, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Tucker
14. MOTHER'S MAIDEN NAME: Alice Ridgeway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
17. INFORMANT: Miss Beatrice E. Tucker- Daughter- Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Azotemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Arteriosclerotic Heart Disease — 1 yr.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — I 2 0 0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1960, to 7-11-, 1960, that I last saw the deceased alive on 7-11-, 1960, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D.
ADDRESS (Street, city or town, state): 5 Shaw Street Annapolis, Md.
DATE SIGNED: 7/12/60
PHYSICIAN'S NAME (Type): James R. Martin MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 14, 60
22c. NAME OF CEMETERY OR CREMATORY: All Hallows Cemetery
22d. LOCATION (City, town, or county) (State): Birdsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home
ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: JUL 18 '60
24b. REGISTRAR'S SIGNATURE: Clifton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7614 07643

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 235 King George St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rosalie Middle PORTER Last VAN NESS
4. DATE OF DEATH: Month July Day 16 Year 1960
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec 12th 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Theodoric Porter
14. MOTHER'S MAIDEN NAME: Bettie Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Carroll Van Ness Address: Owings Mills Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocardial Dis
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
422.2
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from ---- 195- to 7-16 ---, 19 60, that (I) (we) last saw the deceased alive on 7-16 1960 and that death occurred at 6:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/18/60
22c. PHYSICIAN'S NAME (Type): Elmer G. Linhardt
22d. ADDRESS: 3 Chesapeake Ave., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: July 19-1960
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cem't.
23d. LOCATION (City, town, or county) (State): Baltimore Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Snyder Sons
ADDRESS: Annapolis Md
25a. REC'D BY REGISTRAR DATE: JUL 21 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within n 2 [illegible] rs after death. Page 4 may be obtained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7661 — Reg. Dist. No. 07644

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft Geo G. Meade
c. LENGTH OF STAY IN 1b: Few seconds
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
d. STREET ADDRESS: Ark Trailer Ct
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA — Middle – — Last VITALI

4. DATE OF DEATH: Month July — Day 1 — Year 19 60

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/21/26

9. AGE (In years last birthday): 33 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: –

11. BIRTHPLACE (State or foreign country): Salzburg, Austria

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): – No
(If yes, give war or dates of service): –

16. SOCIAL SECURITY NO.: 118-28-9609

17. INFORMANT: (Husband) SP5 Richard J Vitali — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hodgin's disease — INTERVAL BETWEEN ONSET AND DEATH: 1½ years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

DATE SIGNED: 1 July 60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-6-60

22c. NAME OF CEMETERY OR CREMATORY: National

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F.C. Higinbothom, Ellicott City, Md

24a. REC'D BY REGISTRAR DATE: JUL 6 '60

24b. REGISTRAR'S SIGNATURE: Elmer L. Nims

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7662

CERTIFICATE OF DEATH

Reg. Dist. No. 07645

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jewell
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Jewell
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: — Last: Wallace

4. DATE OF DEATH: Month: 7 — Day: 12 — Year: 1960

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 4,

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Henry C. Wallace

14. MOTHER'S MAIDEN NAME: Lydia Pratt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 217-30-3895

17. INFORMANT: John Wallace, Dunkirk, Md. — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — o. m. p. m. — Month: — Day: — Year: 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f (City or town): (County): (State):

21. I certify that I attended the deceased from May, 1960, to July 12, 1960, that I last saw the deceased alive on June 2, 1960, and that death occurred at 8:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Nelson M.D — ADDRESS (Street, city or town, state): Sotterley, Md. — DATE SIGNED: 7-14-60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: 7-16-60 — 22c. NAME OF CEMETERY OR CREMATORY: Moses. — 22d. LOCATION (City, town, or county): Bristol, A.A. — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: P.E. Sewell, Prince Frederick,

24a. REC'D BY REGISTRAR — DATE: JUL 19 '60

24b. REGISTRAR'S SIGNATURE: C. Th. S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07646

CERTIFICATE OF DEATH

7615 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE Arundel Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 10 College Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle — Last WATKINS JR.

4. DATE OF DEATH: Month 7 — Day 3 — Year 1960

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-28-1901

9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Checker-Supply-U.S.N. Acad.
10b. ~~KIND OF BUSINESS OR INDUSTRY~~
11 BIRTHPLACE (State or foreign country): ANNAPOLIS. Md.
12. ~~CITIZEN OF WHAT COUNTRY?~~ U.S.A.

13. FATHER'S NAME: WILLIAM WATKINS Sr.
14 MOTHER'S MAIDEN NAME: Sophie HARRIS

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Elizabeth-WATKINS — Address: ANNA, Md 10 College Ave

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO (b): Myocardial Damage — 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost. DUE TO (c): Diabetes Mellitus — 15 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/2/ , 1960 , to 7/3 , 1960 , that I last saw the deceased alive on 7/3 , 1960 , and that death occurred at 10:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore H. Johnson Jr. M.D
ADDRESS (Street, city or town, state): 37 Calvert St., Annapolis, Md.
DATE SIGNED: 7/5/60

PHYSICIAN'S NAME (Type): Dr. Theodore H. Johnson, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-6-60
22c. NAME OF CEMETERY OR CREMATORY: CARVER MEMORIAL
22d. LOCATION (City, town, or county) (State): LAUREL - Md.

23 FUNERAL DIRECTOR'S SIGNATURE: C. E. Hicks III
ADDRESS: ANNAPOLIS-Md

24a REC'D BY REGISTRAR DATE: JUL 12 '60
24b REGISTRAR'S SIGNATURE: Arthur S Rivers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible] hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7616

07647

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-2, Box-213C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonard; Middle: E.; Last: WEAVER
4. DATE OF DEATH: Month: July; Day: 22; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 8, 1903
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret'd naval architect
10b. KIND OF BUSINESS OR INDUSTRY: Architect
11. BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William E. Weaver
14. MOTHER'S MAIDEN NAME: Minnie Jacobs

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO: —
17 INFORMANT: Address: Alma R. Weaver (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Post operative wound infection + empyema 6 da
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 561.4
DUE TO (c): Hiatal hernia repair and esophageal exploration 10 da

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 7, 1960, to July 21, 1960, that (I) (we) last saw the deceased alive on July 21, 1960 and that death occurred at 2:10 A.M., from the causes and on the date stated above

22a SIGNATURE: Barber C. Palmer, Jr. M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 7/22/60
22c PHYSICIAN'S NAME (Type): Barber C. Palmer
22d. ADDRESS: 77 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 7-25-60
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
23d. LOCATION (City, town, or county) (State): Prince George Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Ryon & Sons
ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: JUL 25 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7663

07648 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 3558 West Shore Rd. Green Haven

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle Henry Last Weidenhoft

4. DATE OF DEATH: Month July Day 5th. Year 19 60

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/13/86
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired conductor of The P.R.R.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany, Europe.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Theresa Weidenhoft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 717-07-0396
17. INFORMANT Address: Mrs. Edna Weidenhoft (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ 7/5/60

22a. BURIAL, CREMATION, REMOVAL (Specify): (illegible)
22b. DATE THEREOF: 7-8-60
22c. NAME OF CEMETERY OR CREMATORY: (illegible)
22d. LOCATION (City, town, or county) (State): (illegible)

23. FUNERAL DIRECTOR'S SIGNATURE: (illegible) ADDRESS: (illegible)
24a. REC'D BY REGISTRAR DATE: JUL 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7617 Reg. Dist. No. 3764

1. PLACE OF DEATH
a. COUNTY A.A.Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY AACO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS Severn Hgts.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Alice Middle: Lost: Wheatly
4. DATE OF DEATH Month: 7 Day: 16 Year: 1960

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-21-35
9. AGE (In years last birthday) 24 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Worker
10b. KIND OF BUSINESS OR INDUSTRY Naval Academy-Annapolis
11. BIRTHPLACE (State or foreign country) Balto. City-Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Vayhn Shinaberry
14. MOTHER'S MAIDEN NAME Helen V. Ryder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Mrs. Bertha Bocock-Manley Park Address 15-Green Way-Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - Rabbit Run & Cypress Creek Road
20c. TIME OF INJURY Hour: 11:35 p.m. Month, Day, Year: 7-16 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) (County) A.A.Co (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) E. Linhardt
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 7.16.60.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 20 July 1960
22c. NAME OF CEMETERY OR CREMATORY Glen Haven
22d. LOCATION (City, town, or county) Glen Burnie (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE T. V. Singleton ADDRESS Glen Burnie, Md
24a. REC'D BY REGISTRAR DATE JUL 21 '60
24b. REGISTRAR'S SIGNATURE Carlton S. Heard

TO DE[illegible] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please exe[illegible] cute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funer[illegible] rector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7664

07650

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 101 14 th. Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn Park
d. STREET ADDRESS: 101 14th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIOLA Middle WILLIAR Last
4. DATE OF DEATH: Month July Day 19 Year 1960

5 SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 4, 1903
9. AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S.

13 FATHER'S NAME: George T. Stinchcomb
14. MOTHER'S MAIDEN NAME: Ida M. Parrish

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: 213-09-6091
17 INFORMANT: Mr. Lee G. Williar — Address: Same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rheumatic Heart Disease
DUE TO
(b):
DUE TO
(c):

4-16X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 7/13 1959, to 7/19, 1960 that (I) (~~we~~) last saw the deceased alive on 7/19 1960, and that death occurred at 5:16 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Morton M. Krieger M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: July 20, '60
22c. PHYSICIAN'S NAME (Type): Morton M. Krieger
22d. ADDRESS: 5010 A Gov. Ritchie Hgwy. Balto 22 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: July 21, 1960
23c NAME OF CEMETERY OR CREMATORY: Western Cemetery
23d LOCATION (City, town, or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Geo J Gosnell
ADDRESS: 4001 Hichie Hgwy. Balto 25
25a. REC'D BY REGISTRAR DATE JUL 25 '60
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7665

Reg. Dist. No. 0765

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): P.O. Glen Burnie
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 101 Greeway Rd. Marley Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Terry Middle Lee Last Windeshein

4. DATE OF DEATH: Month July Day 9th Year 1960 19

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/18/58

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Windeshein

14. MOTHER'S MAIDEN NAME: Daisy Lilley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Mr and Mrs. J. Windeshein (parents.)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary infection — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7/ /60

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12th July 1960

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or county) (State): Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. P. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JUL 13 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and [illegible] with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG268 8-2-60 et

7666

07652

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 Hollywood Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS 211 Hollywood Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Charlotte Middle E. Last Heidhall

4. DATE OF DEATH Month 7 Day 21 Year 19 60

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 3-26-87

9. AGE (In years last birthday) 73/72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gabriel Solomon

14. MOTHER'S MAIDEN NAME Mary E. Sollohub

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Family - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease
420.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: many years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Febr. 4, 19 59 to July 20, 19 60 that I last saw the deceased alive on July 21, 19 60, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Florian P Nadolski M.D.

ADDRESS (Street, city or town, state) 2703 Hammonds Ferry Rd

DATE SIGNED 7-22-60

PHYSICIAN'S NAME (Type) Florian P Nadolski, M.D. Baltimore 27, Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 7-25-60

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill

22d. LOCATION (City, town, or county) (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCleary & Boone Fort Ave.

24a. REC'D BY REGISTRAR DATE JUL 27 '60

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7667

CERTIFICATE OF DEATH

07653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Plaza Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 145 Calvert Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: — Last: Young

4. DATE OF DEATH: Month: July — Day: 30, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 18, 1901

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer - Cook

10b. KIND OF BUSINESS OR INDUSTRY: ~~Unknown~~

11. BIRTHPLACE (State or foreign country): ~~Unknown~~ Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? ~~Unknown~~ U.S.A.

13. FATHER'S NAME: William Parker

14. MOTHER'S MAIDEN NAME: Ella Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ~~Unknown~~ — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 226-18-4436 ~~Unknown~~

17. INFORMANT — Address: Mrs. Alice Brown-A.A.Co. D.P.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive cardio renal vascular disease — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.
DUE TO (b):
DUE TO (c):

4 4 2 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from July 14, 1960 to July 30, 1960 that (I) (we) last saw the deceased alive on July 23, 1960, and that death occurred at 9.30 A. M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Pair M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: July 30, 1960

22c. PHYSICIAN'S NAME (Type): James M. Pair, M.D.

22d. ADDRESS: 400 N. Carrollton Ave. Balto. 23, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 2-60

23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

23d. LOCATION (City, town, or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C.E. Hicks III Annapolis, Maryland

25a. REC'D BY REGISTRAR — DATE: AUG 3 '60

25b. REGISTRAR'S SIGNATURE: Clifton L. Thomas